



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

View Alert Process Failures  
and the Impact on Patient  
Care at the Central Alabama  
Veterans Health Care  
System in Montgomery



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## Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection in response to allegations that significant failures related to the management of view alert notifications (view alerts) at the Central Alabama Veterans Health Care System (system) in Montgomery placed patients at risk. View alerts are one tool for communicating patient test results to providers and include laboratory tests, diagnostic imaging procedures, and diagnostic procedures. View alerts may also be generated for administrative consults to facilitate one-way communication, such as transfers or scheduling. View alerts are automatically created and displayed to providers in the electronic health record (EHR) according to Veterans Health Administration (VHA) guidelines and system preferences.<sup>1</sup>

The OIG evaluated allegations of

- A backlog of 5,000–10,000 unaddressed view alerts each for at least 12 providers;
- Compromised patient care due to abnormal laboratory and imaging results that were either not managed or not managed timely, including
  - Potential delays in cancer diagnosis for hundreds of patients,
  - Failure to provide treatment to hundreds of patients with diabetes and abnormal glucose levels or patients with heart disease and abnormal cholesterol levels, and
  - Failure to communicate abnormal laboratory and imaging test results to providers and patients;
- Closure of unscheduled community care consults after 90 days; and
- A lack of system leadership action concerning the backlog of view alerts despite awareness of the issue.

A provider may manage the results or communications in a patient's EHR without addressing the view alert. View alerts can be displayed to more than one provider involved in the care of the patient. When one provider addresses the view alert by opening it and viewing the result or communication, it does not remove the view alert sent to other providers. Unaddressed view alerts do not necessarily correlate to unmanaged clinical results or administrative consults; however, they will continue to accumulate until they are addressed. The system estimated a backlog of unaddressed view alerts of nearly 750,000 in May 2019 and 47,000 in November 2019.

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<sup>1</sup> VA, *Vista Computerized Patient Record System (CPRS) Setup Guide*, October 2019.

The OIG conducted EHR reviews of patients with unaddressed view alerts and determined that a total of 33 patients had clinical or treatment issues that had not been adequately managed by the system as of February 3, 2020.<sup>2</sup> The patients were referred to the system for follow-up. The OIG reviewed the system's action plans for the referred patients and found all plans to be acceptable.

The OIG did not substantiate that at least 12 providers had each accumulated more than 5,000 view alerts. However, the OIG confirmed that nine providers each had more than 5,000 view alerts at some point between July 23 and December 2, 2019. Because of the rolling nature of view alerts, the OIG could not definitively determine how many of them were for laboratory tests or imaging results over six months old. Nevertheless, the OIG confirmed during interviews that providers were not consistently responding to view alerts within the required time frame for test result notification. The OIG determined that contributing factors included inactive providers without designated surrogates and inadequate provider training.

The OIG found that unaddressed view alerts for inactive providers without designated surrogates contributed to the increased backlog and identified 284 unaddressed view alerts of inactive providers without a designated surrogate that involved abnormal laboratory tests and imaging results, discontinued community care consults, or suicidal behavior. During the review of this unaddressed view alert backlog, the OIG found opportunities for the system to follow up on clinical concerns including diabetes management, thyroid imaging, and urology care. Ten patient cases requiring further review, six of which were from one provider, were sent to the system to ensure actions were taken.

VHA policy requires that all providers have coverage, such as the designation of a surrogate, during their absence. The surrogate is responsible for managing and responding to incoming view alerts for the ordering provider to ensure patient care is not interrupted and view alerts are addressed. Providers generally reported that the surrogate designation process was not effective because the increased volume of view alerts made it difficult for the provider with surrogate duties to address both sets of view alerts.

Although training and resources to support providers in managing view alerts was available, it did not appear that those services were widely communicated or utilized by providers. System staff members told the OIG that view alerts not requiring action or intervention increased the number of daily view alerts received by providers to an unmanageable volume and left them feeling overwhelmed. The OIG was told that although system clinical applications coordinators were available to train providers, training did not consistently occur.

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<sup>2</sup> The 33 patient cases were identified during various aspects of the inspection: 10 from the review of the unaddressed view alert backlog, five from the review of abnormal lab results, five from the review of abnormal prostate specific antigen results that were provided by the complainant, five from the review of abnormal imaging results, and eight from the review of discontinued and canceled consults.

The OIG substantiated that of the patients reviewed, some patient care was compromised because abnormal laboratory and imaging results were either not managed or not managed within the required time frame. Although the system had a policy for provider and patient notification of critical test results, it did not have a policy regarding communication of all test results to ordering providers and to patients as required by VHA policy.

The OIG substantiated that some patients were at risk for delayed cancer diagnosis because of the lack of timely provider follow-up. If providers do not manage abnormal test results and take appropriate actions within the required time frame, delays in cancer diagnosis, and subsequently treatment, can occur. In one example identified by the OIG in a review of imaging view alert data, a patient was ultimately diagnosed with pancreatic cancer by community providers after the system provider did not manage abnormal laboratory tests and imaging results for over two months.

In a review of 10 patients provided by the complainant, the OIG identified the failure of a system provider to manage a patient's elevated prostate specific antigen (PSA) levels, despite the patient's repeated provider visits over the course of nearly two years. The patient was ultimately diagnosed with prostate cancer by a community provider. The OIG's review of the other nine patients revealed a provider delay in responding to view alerts for elevated PSA levels of 10–376 days. Four patients had acceptable follow-up care; the remaining five patients' cases were referred to the system for further action.

The OIG did not substantiate that hundreds of patients with either abnormal glucose or cholesterol levels were never treated. However, the OIG substantiated that patients with view alerts for abnormal laboratory and imaging test results were not consistently notified as required by VHA. The provider or designee must document any communication and subsequent clinical actions in the patient's EHR "in response to critical, urgent, and clinically significant test results that require therapeutic intervention or action."<sup>3</sup>

The OIG reviewed 225 patients' EHRs with abnormal laboratory test results that would have generated view alerts and found that 88 patients were not notified of their laboratory results. Of those, the OIG focused on 22 patient cases where there was increased potential for adverse clinical outcomes but no documented evidence of follow-up. The OIG determined five patients required follow-up for abnormal laboratory test results; the five patient cases were referred to the system for action.

The OIG reviewed 275 patients' EHRs with abnormal imaging view alerts and found that 99 patients were not notified of their imaging results. The OIG further reviewed 21 (of the 99) selected patients EHRs with abnormal results where there was increased potential for adverse clinical outcomes, and provided five patient cases to the system for additional action.

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<sup>3</sup> VHA Directive 1088, Communicating Test Results to Providers and Patients, October 7, 2015.

The OIG did not substantiate that the system excluded teleradiologists from the requirement to communicate abnormal and critical test results to ordering providers or their designees as was alleged during an inspection interview. The OIG determined that diagnostic providers notified ordering providers of abnormal and critical laboratory and imaging test results as required by VHA.<sup>4</sup>

Although it was substantiated that unscheduled community care consults were administratively closed after 90 days, the OIG found that these actions complied with VHA requirements. If a consult is discontinued or canceled for any reason, a view alert is automatically sent to the ordering provider. After reviewing the view alert, ordering providers must take appropriate action to either edit and resubmit the canceled consult or enter a new consult if the original one was discontinued. The OIG reviewed 385 administratively closed community care consults entered from June 1 to November 30, 2019, and found that ordering providers did not consistently take appropriate actions to edit and resubmit canceled consults as required by VHA due to either no action or incorrect ordering provider action. Ultimately, two canceled consults and six discontinued consults were referred to the system for further action.

The OIG substantiated that the interim Chief of Staff (COS) became aware of the unaddressed view alert backlog after being detailed to the position in May 2019. The OIG found that while the interim COS and other leaders took actions to reduce the number of view alerts, the leaders' responses did not include sufficient activities needed to ensure patient care and safety. System leaders took actions that included overtime for providers to address their view alerts but did not provide guidance or clear instructions on how to prioritize view alerts for review and disposition, or how to document the actions related to clearing the unaddressed view alert backlog. When interviewed, the OIG was told by the interim COS that "management of view alerts should be very much like getting today's work done today."

In addition, because system leaders did not initially incorporate oversight processes, such as audits, they could not be assured that the view alerts were being appropriately managed (as opposed to just "deleting" the view alert). Following the OIG's visit, the system reported implementing weekly audits of unaddressed view alerts. Due to the recency of the weekly audits, the OIG was unable to determine their effectiveness.

The OIG is concerned that the issue of significant failures related to management of view alerts is not limited to the system. In 2019, the OIG published a report related to this topic and made a recommendation to the Under Secretary for Health that identified the need for a fail-safe (computer) system that allowed communication and tracking of test results to provider(s) who coordinate patient notification and appropriate follow-up testing and clinical management, and

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<sup>4</sup> VHA Directive 1088.

with the ability to monitor actions taken by the responsible provider(s).<sup>5</sup> As of November 4, 2020, the recommendation remained open.

The OIG made one recommendation to the Under Secretary for Health to maintain consistent acting or interim leadership while expediting the hiring of permanent leaders.<sup>6</sup>

The OIG made one recommendation to the VA Southeast Network Director to ensure continued collaboration with the system to facilitate compliance with guidelines related to view alert management and monitor for ongoing efficiency and sustainability.

The OIG made nine recommendations to the System Director related to evaluation of the current view alert management process, provider training and support for the clinical management of view alerts, guidance and training on the designation of surrogates, evaluation of two cases discussed in this report to assess the need for further action, retrospective reviews and audits focusing on the unmanaged results and unscheduled community care consults, development and implementation of a policy to address the communication of all test results, and completion of the pending actions for the 33 patient cases referred to the system by the OIG.

## Comments

The Acting Under Secretary for Health, Veterans Integrated Service Network Director, and System Director concurred with the findings and recommendations and provided acceptable action plans. The OIG will follow up on the planned actions until they are completed.



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<sup>5</sup> VA OIG, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Services Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

<sup>6</sup> Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge, who had the authority to perform the Under Secretary's functions and duties. Effective January 20, 2021, he was appointed to Acting Under Secretary for Health with the continued authority to perform the functions and duties of the Under Secretary.

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## Abbreviations

ADPCS	Associate Director for Patient Care Services
CAC	clinical applications coordinator
COS	Chief of Staff
CPRS	computerized patient record system
DUSHOM	Deputy Under Secretary for Health for Operations and Management
EHR	electronic health record
OIG	Office of Inspector General
PSA	prostate specific antigen
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Integrated and Systems Technology Architecture



## Introduction

The VA Office of Inspector General (OIG) conducted an inspection in response to allegations that significant failures related to management of view alert notifications (view alerts) at the Central Alabama Veterans Health Care System (system) in Montgomery placed patients at risk.

## Background

The system is part of Veterans Integrated Service Network (VISN) 7 and includes the West Campus in Montgomery and the East Campus in Tuskegee, as well as three community-based outpatient clinics. The system offers primary, medical, and surgical care; mental health programs; and a homeless domiciliary. The system, which served 49,702 patients from October 1, 2018, to September 30, 2019, is classified by the Veterans Health Administration (VHA) as Level 1c (mid-high complexity).<sup>1</sup>

## System Leadership

In general, strong, stable leadership correlates positively with the functional status of an organization.<sup>2</sup> In this case, the system had a long-standing history of staffing challenges at the leadership level and had been a below average or low performer in Strategic Analytics for Improvement and Learning measures for at least three years.<sup>3</sup> At the time of the OIG site visit in early December 2019, the system's executive leadership team had an interim Director, acting Deputy Director, interim Chief of Staff (COS), acting Associate Director, acting Assistant Director, and an interim Associate Director for Patient Care Services (ADPCS). As a result, the OIG was unable to interview responsible leaders who knew, or should have known, about the history of view alert issues and the system's corrective actions discussed in this report.

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<sup>1</sup> VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Level Model Fact Sheet," December 15, 2017. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

<sup>2</sup> Governance Institute. *Leadership in Healthcare Organizations*. San Diego, California, Winter 2009. The Joint Commission. [https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/wp\\_leadership\\_standardspdf.pdf?db=web&hash=86F0223A5C016F833DA3DDB1C62F5D20](https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/wp_leadership_standardspdf.pdf?db=web&hash=86F0223A5C016F833DA3DDB1C62F5D20). (The website was accessed on February 25, 2020.)

<sup>3</sup> VHA's Office of Reporting, Analytics, Performance, Improvement and Deployment of the Office of Organizational Excellence uses the Strategic Analytics for Improvement and Learning model to understand a system's performance in relation to quality and efficiency and capacity domains.

## View Alerts

VHA outlines a method for communicating test results to providers through view alerts in the Computerized Patient Record System (CPRS).<sup>4</sup> The content of view alerts may include the results of laboratory tests, diagnostic imaging, and diagnostic procedures.<sup>5</sup> View alerts may also be generated for administrative consults to facilitate one-way communication, such as transfers or scheduling. Some view alerts are mandatory and cannot be deactivated by providers, while other view alerts are optional.

Although view alerts are one tool for communicating test results, it is possible for providers to manage or choose not to manage the test result regardless of whether they address the view alert. View alerts can be displayed to more than one provider involved in the care of a patient. When one provider addresses the view alert by opening it and viewing the result or communication, it does not remove the view alert sent to other providers. Unaddressed view alerts do not necessarily correlate to unmanaged clinical results or administrative consults.

VHA policy states that facilities should evaluate the numbers and types of CPRS (view alert) notifications providers receive to ensure they are “effective, responded to in a timely manner, and do not create unnecessary information burdens on ordering providers or designees.”<sup>6</sup> VHA policy also requires that facilities limit the use of mandatory alerts and do not create unnecessary information burdens on ordering providers.<sup>7</sup> The system collaborated with the VISN 7 Chief Health Informatics Officer, as a technical subject matter expert, to provide view alert education and provider view alert expectations. According to the Chief Health Informatics Officer, the view alert process is supposed to augment the provider’s ability to respond to alerts that need clinical judgment or an action to be taken.

## Prior OIG Reports

A search of prior healthcare reviews since 2015 identified three OIG reports with issues outlined in this report.

In 2015, the OIG published a report, *Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System*, which identified multiple clinical and administrative deficiencies across system operations.<sup>8</sup> The OIG reported that many

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<sup>4</sup> VHA Directive 1088.

<sup>5</sup> VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016. “A laboratory test is defined as an examination, diagnostic, or monitoring procedure on a human specimen removed from the body to determine specific information for diagnosis, treatment, or prevention of disease and to detect the impairment of health status, or to assess the health of human beings.”

<sup>6</sup> VHA Directive 1088.

<sup>7</sup> VHA Directive 1088.

<sup>8</sup> VA OIG, *Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama*, Report No. 14-04530-452, July 29, 2015.

of the key leaders and managers were in interim or acting roles including the System Director, COS, ADPCS, and the chiefs of Ambulatory Care, Mental Health, Human Resources, Non-VA Care Coordination, the Business Office, and Radiology. As a result, the OIG was “frequently unable to interview people with historical knowledge of, or responsibility for, many of the issues” identified in that report. The OIG made two recommendations to the Under Secretary for Health related to the leadership challenges:

- Provide consistent interim leadership to the system in the form of highly skilled leaders who could lead systemic improvements and cultural change until such time as the leadership positions could be filled permanently.
- Directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of three years.

On a quarterly basis, VHA provided updates regarding its efforts to install a stable executive leadership team. Through these updates, the VISN reported that as of June 2019, all executive leadership positions had been filled by permanently assigned staff except for the COS and the Associate Director. The OIG closed the recommendation on September 12, 2019, after the facility provided evidence that recruitment efforts would continue.

In 2017, the OIG published a second report, *Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times, VA Medical Center in Montgomery, Alabama*. The OIG investigation was initiated to determine if employees intentionally deleted patient names from an electronic waiting list to give the appearance the list was shorter.<sup>9</sup> The OIG determined that VA addressed issues involving consults that “had been canceled, denied, or administratively completed without patients being scheduled for appointments or receiving care.” As a result of the investigation, four senior managers were no longer employed at the system. The OIG referred the investigation to the VA’s Office of Accountability Review.

The OIG is concerned that the issue of significant failures related to management of view alerts is not limited to this system. In 2019, the OIG published the report, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*.<sup>10</sup> In that report, the OIG made a recommendation to the VHA Under Secretary for Health that identified the need for a fail-safe (computer) system that allowed communication and tracking of test results to provider(s) who coordinate patient notification and appropriate follow-up testing and clinical management, and with the ability to monitor actions taken by the responsible provider(s). As of November 4, 2020, the recommendation remained open.

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<sup>9</sup> VA OIG, *Administrative Summary of Investigation in Response to Allegations Regarding Patient Wait Times, VA Medical Center in Montgomery, Alabama*, Report No. 14-02890-96, May 24, 2017.

<sup>10</sup> VA OIG, *Delay in Diagnosis and Subsequent Suicide at a Veterans Integrated Service Network 15 Medical Facility*, Report No. 19-00022-153, June 26, 2019.

## Allegations

The OIG received a complaint on September 20, 2019, and received additional allegations during subsequent interviews, alleging significant failures related to view alert management which placed patients at risk:

- At least 12 primary care providers (providers) each accumulated and did not address 5,000–10,000 view alerts, many of which were laboratory and imaging test results over six months old.<sup>11</sup>
- Patient care was being compromised because many abnormal laboratory and imaging results were either not managed or not managed timely:<sup>12</sup>
  - Hundreds of patients were potentially at risk for delayed cancer diagnoses. The complainant provided a list of 10 patients with elevated [prostate specific antigens](#) (PSAs) that were not managed.<sup>13</sup>
  - Hundreds of patients with [diabetes](#) and abnormal [glucose](#) levels or patients with heart disease and abnormal cholesterol levels were never treated.
  - Abnormal laboratory and imaging tests results were not communicated to providers or patients.<sup>14</sup>
- Unscheduled community care consults were administratively closed after 90 days, regardless of the patient’s problem.<sup>15</sup>
- System leaders were made aware of the concerns and identified the extent of the backlog of unaddressed view alerts but did not take action.<sup>16</sup>

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<sup>11</sup> The six-month period was presented by the complainant in the allegation.

<sup>12</sup> The complainant alleged provider failures related to abnormal laboratory and imaging results, which spanned a spectrum from not very clinically significant to highly significant. For the purpose of this review, the OIG interpreted the complaint to mean abnormal laboratory tests and imaging results requiring clinical intervention.

<sup>13</sup> Underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together.

<sup>14</sup> This concern was identified during an interview with the complainant and was not part of the original allegation.

<sup>15</sup> This concern was identified during an interview with the complainant and was not part of the original allegation. For the purposes of this report, “closed” means “discontinued.” For purposes of this report, “administratively closed” means consults that were canceled and then discontinued after 90 days.

<sup>16</sup> The interim Director defined a backlog as a high volume of unaddressed system view alerts that providers had challenges processing.

## Scope and Methodology

The OIG conducted a site visit December 3–5, 2019.

The OIG interviewed VISN and system leaders as well as system staff knowledgeable about the events under discussion. In addition to reports, policies, and meeting minutes, the OIG reviewed additional electronic health record (EHR) and system patient data as indicated below:

- Unaddressed view alerts (1,218) of inactive users without designated surrogates from July 24 through December 4, 2019<sup>17</sup>
- The EHRs of the 10 patients with elevated PSAs provided in the original complaint
- View alerts (12,221) from ordering providers with abnormal, including critical, laboratory tests or imaging results from January 1 through November 23, 2019, from which the OIG identified and reviewed
  - A randomized sample of 225 abnormal, including critical, laboratory tests, and
  - A randomized sample of 275 abnormal, including critical, imaging results
- Discontinued community care consults (385) from June 1 through November 30, 2019

The reviewed documents covered the period of October 1, 2018, to September 30, 2019, unless otherwise noted.

The OIG determined that a total of 33 patients had clinical or treatment issues that had not been adequately managed by the system as of February 3, 2020, and were referred to the system for follow-up. The OIG reviewed the system's action plans for the referred patients and found all plans to be acceptable.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at

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<sup>17</sup> Inactive users are providers that have separated from the system and are no longer providing primary care to patients.

5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

## Sequence of Events

On March 8, 2017, a Deputy Under Secretary for Health for Operations and Management (DUSHOM) memorandum outlined the View Alert Optimization Program to all VISN directors, which required completion of several tasks for each VA medical center and VISN:

- Standardization of mandatory view alerts, with a recommended restriction of 10 but allowing up to 12
- Submission of a consolidated pre-implementation report that contained the number of mandatory view alerts and the average number of daily view alerts received by providers
- Training of providers on best practices for customizing and processing view alerts
- Submission of a post-implementation report containing the number of mandatory view alerts, the average number of daily view alerts received by providers, and the percentage of providers who received view alert training

Prior to implementation of the View Alerts Optimization Program, the system reported having 20 mandatory view alerts with providers receiving an average of 106 view alerts per day. Further, the system reported that all providers received view alert training. After implementation, the system reported having 12 mandatory view alerts with providers receiving an average of 85 view alerts per day. Provider training documents showed that 81 percent of providers had received view alert training as of May 31, 2017.

System staff told the OIG that the management of view alerts was not a focus until May 2019 following a routine visit by the VHA Office of Reporting, Analytics, Performance, Improvement, and Deployment team.<sup>18</sup> At that time, system leaders estimated a backlog of unaddressed view alerts of nearly 750,000 (see table 1). The OIG was told of the unaddressed view alert backlog from multiple staff.

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<sup>18</sup> VHA's Office of Reporting, Analytics, Performance, Improvement, and Deployment provides support to the field and leadership with analytics, tools, consultation and training to assess how an organization is performing. A team of expert improvement coaches can be dispatched quickly to low-performing facilities to oversee improvement and assist in meeting goals. <https://vaww.va.gov/RAPID/index.asp>. (The website was accessed on February 20, 2020.)

**Table 1. Backlog of System Staff Unaddressed View Alerts by Month**

Month and Year	Number of Unaddressed (Backlogged) View Alerts
May 2019	749,852
July 2019	103,000
August 2019	75,000
September 2019	58,000
November 2019	47,000
March 2020	47,557

*Source: System staff interviews, email, or both.*

*Note: The data that appear in this table are for the months that the facility had data available.*

System leaders and responsible managers reported to the OIG actions that had been taken beginning in May 2019 to ensure view alerts were responded to timely and to address the backlog:

- Collaborated with a VISN work group for provider education, provider view alert expectations, and processes for inactive users; provided service line education; and educated providers on expectations for daily review of view alerts
- Mandated providers with greater than 400 unaddressed view alerts to work on weekends to immediately address their backlogs
- Assembled a system View Alerts Subcommittee to address, monitor, and report view alert management and reduction. The Subcommittee discusses provider education and resources as a standing agenda items at biweekly meetings
- Sent service chiefs weekly reports listing staff with over 500 unaddressed view alerts. Service chiefs were responsible for assisting staff in management of view alerts
- Outlined that providers with greater than 500 unaddressed view alerts for more than 30 days could be placed on a focused professional practice evaluation for 30-90 days<sup>19</sup>

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<sup>19</sup> VHA Handbook 1100.19 *Credentialing and Privileging*, October 15, 2012. Focused professional practice evaluation is “an oversight process...whereby the facility evaluates the privilege-specific competence of a practitioner”, “at the time of initial appointment”, and “when a question arises regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care.”



According to the interim COS, as of November 2019, the estimated unaddressed view alert backlog across the system was about 47,000. When interviewed about the expectation for addressing view alerts, the interim COS stated that “management of view alerts should be very much like getting today’s work done today.”

## Inspection Results

### 1. Backlog of Unaddressed View Alerts

The OIG did not substantiate that at least 12 providers had each accumulated more than 5,000 view alerts. However, the OIG confirmed that nine providers each had more than 5,000 view alerts at some point between July 23 and December 2, 2019. Because of the rolling nature of view alerts, the OIG could not definitively determine how many of them were for laboratory tests or imaging results over six months old.<sup>20</sup> Nevertheless, the OIG confirmed that providers were not consistently responding to view alerts within the required time frame for test result notification.

VHA describes view alerts as “CPRS notifications to providers about clinical information,”<sup>21</sup> including the results of laboratory tests, diagnostic imaging and procedures, and administrative consults for one-way communication.

The OIG reviewed the system’s number of unaddressed clinical view alerts on five dates and determined that the number decreased between July 23 and December 2, 2019.

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<sup>20</sup> View alerts are constantly being cleared and new ones received. Because of the volume of view alerts in question, it was impractical for the OIG to evaluate each view alert and the associated EHR documentation individually.

<sup>21</sup> VHA Memorandum, *View Alerts Optimization Program*, March 8, 2017.

**Table 2. Backlog of Ambulatory Care Provider Unaddressed Clinical View Alerts  
by Date**

Date	Total Backlog of Unaddressed Clinical View Alerts	Number of Providers	Highest for One Provider
July 23, 2019	80,597	56	17,682
August 29, 2019	50,820	55	7,604
October 3, 2019	38,198	59	6,797
November 25, 2019	33,310	61	6,119
December 2, 2019	29,591	60	5,238

*Source: OIG analysis of view alert lists provided by the system.*

*Note: Alerts are messages that provide information or prompt to act on a clinical event.*

*Clinical alerts (also referred to as “view alerts”) are electronic notifications of the results of various tests, documents that require signature, transactions taken on clinical consultations, orders requiring attention or communication from another CPRS end user involved in a patient’s care.*

The OIG found that, due to a failure to focus after the 2017 DUSHOM View Alert Optimization Program memorandum (see [Sequence of Events](#)), the backlog of unaddressed view alerts increased. The OIG was told in an interview that this backlog was due to contributing factors such as inactive providers without designated surrogates and inadequate provider training.<sup>22</sup>

### **Inactive Providers Without Designated Surrogates**

The OIG found that unaddressed view alerts for inactive providers without designated surrogates contributed to the increased backlog of unaddressed view alerts.

VHA provides a team-based primary care model to emphasize timely, coordinated, and continuous care, and requires that all providers have coverage, such as the designation of a surrogate, during their absence. The surrogate is responsible for managing and responding to incoming view alerts for the ordering provider to ensure patient care is not interrupted and view

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<sup>22</sup> VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. This directive was amended on May 26, 2017. A surrogate is a covering provider arranged to ensure continuity of patient care when a patient’s provider is not available. “For CPRS coverage, this can be accomplished by setting the covering provider as a “surrogate” in CPRS.”

alerts are addressed.<sup>23</sup> The VISN Chief Health Informatics Officer confirmed to the OIG that the system had not outlined requirements for designating surrogates or their responsibilities.

The system provided the OIG a list of unaddressed view alerts for inactive providers without designated surrogates from July 24 to December 4, 2019. The OIG was told that if a provider no longer worked at the system and a surrogate had not been designated, the view alerts were sent to clinical applications coordinators (CACs).<sup>24</sup> Staff told the OIG that the CACs tried several strategies to ensure view alerts were addressed. For example, a CAC designated other providers to receive the alerts for clinical management. This process was stopped by the interim COS because providers stated it was overwhelming to receive their own as well as another provider's view alerts. The CACs then started sending a list of unaddressed view alerts to the respective service-line managers requesting the assignment of a designee, as well as designating those service-line managers to receive the unaddressed view alerts. According to a CAC, this strategy was also halted by the interim COS with no reason given.

In addition, providers generally reported that the surrogate designation process was not effective because the increased volume of view alerts made it difficult for providers with surrogate duties to address both sets of view alerts. The OIG reviewed 1,218 unaddressed view alerts of inactive users without designated surrogates issued from July 24 through December 4, 2019, and identified 284 that involved abnormal laboratory tests and imaging results, discontinued community care consults, or suicidal behavior. These view alerts represented the most potential for adverse clinical outcomes if not acted upon. During the review of the 284 unaddressed view alerts, the OIG found opportunities for the system to follow-up on clinical concerns including diabetes management, [thyroid](#) imaging, and [urology](#) care. The OIG determined that 10 patient cases required further review, six of which were from one provider. The patient cases were sent to the system to ensure actions were taken as appropriate.

## Inadequate Provider Training

The OIG found that training and resources to support providers in managing view alerts were available at the system. However, it did not appear those services were widely communicated to or utilized by providers. System staff members told the OIG that view alerts not requiring action or intervention increased the number of daily view alerts received by providers to an unmanageable volume and left them feeling overwhelmed. The 2017 DUSHOM memo directed facilities to train providers on managing view alerts (see [Sequence of Events](#)).

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<sup>23</sup> VHA Handbook 1101.10(1).

<sup>24</sup> VHA Handbook 1907.01, *Health Information Management*, March 19, 2015. CACs are “assigned to coordinate the use of the CPRS and other Veterans Integrated and Systems Technology Architecture (VistA) software programs for end users.”

In April 2017, the system CACs provided training to 47 of 58 providers on managing view alerts. Facility staff reported training included some combination of a PowerPoint presentation, CPRS training, online sessions, or one-on-one sessions. However, during interviews, some providers stated they had little ongoing training related to view alert settings, nor had they received tips related to best practices. The OIG was told that CACs have the ability but did not consistently provide view alert training to instruct providers on how to customize and manage their view alerts. The OIG determined that providing view alert training to instruct providers on how to customize and manage their view alerts could lead to improvements in efficiency and reductions in the unaddressed view alert backlog.

In addition, some providers shared that although they had administrative time in their schedules to manage the test results or other event that triggered the view alert, the time was insufficient and was often used for providing patient care. Providers told the OIG that they utilized weekend overtime for clearing the backlog of unaddressed view alerts and managing view alerts took time based on the level of review and actions required.<sup>25</sup>

## 2. Patient Care Concerns Related to View Alerts

The OIG substantiated that of the patients reviewed, some patient care was compromised because abnormal laboratory and imaging results were either not managed or not managed within the required time frame. The OIG identified the lack of timely provider follow-up of abnormal laboratory test and imaging results as a contributing factor in two patients' adverse clinical outcomes, discussed below.<sup>26</sup>

Laboratory tests and imaging results are important tools for patient management. "Abnormal test results are results that fall outside a specified normal reference range, are unexpected, or could indicate the presence of disease." According to VHA, an abnormal test result is further defined as one of the following: (1) critical life threatening, "which must be acted upon by the ordering provider or their designee immediately or within a short window of time and could result in severe morbidity or mortality if left untreated;" (2) urgent non-life threatening, "which must be acted upon...within a relatively urgent timeframe;" or (3) clinically significant, which "requires action...but not necessarily in an immediate or urgent time frame."<sup>27</sup> Although the system had a policy for provider and patient notification of critical test results, it did not have a policy

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<sup>25</sup> The OIG was informed that some providers managed view alerts by documenting additional progress notes, sending patient result letters, or having the nurse respond to the alerts and messages.

<sup>26</sup> Within in the context of this report, the OIG considered an adverse clinical outcome to be death, a progress of disease, worsening prognosis, suboptimal treatment, or a need for higher level care. The OIG recognizes that avoidable delays associated with the deficiencies discussed in this report may affect the convenience and quality of care received.

<sup>27</sup> VHA Directive 1088.

regarding communication of all test results to ordering providers and to patients as required by VHA.<sup>28</sup>

## Delayed Cancer Diagnosis

The OIG substantiated that some patients were at risk for delayed cancer diagnoses because of the lack of timely provider follow-up. If providers do not manage abnormal test results and take appropriate actions within the required time frame, delays in cancer diagnosis, and subsequently treatment, can occur. The ordering provider is responsible to review “the status of ordered consults to make sure that the patient receives timely care” and to “determine if additional clinical measures are necessary.”<sup>29</sup> View alerts are the primary mechanism by which providers are notified of abnormal results and consult status, and provide the opportunity for the prompt response that is required.

### *Delay in Managing Abnormal Laboratory Tests and Imaging Results*

In one example identified by the OIG in a review of imaging view alert data, a patient (Patient 1) was ultimately diagnosed with [pancreatic cancer](#) by community providers after the system provider did not manage abnormal laboratory tests and imaging results. Patient 1, in their mid-70s, was evaluated in mid-April 2019, during a routine visit. At that appointment, the provider discussed Patient 1’s laboratory tests that documented abnormal results in liver function and ordered additional laboratory tests and an abdominal computed tomography to determine the cause of the abnormalities. The repeat laboratory tests were significantly elevated compared to the tests done the previous week. A radiology report dated April 16 documented a nodule around the [pancreas](#). The report recommended that the ordering provider consider a follow-up exam with contrast.

The imaging report abnormal result required follow-up from the provider. There was no EHR documentation that these results were managed or that the patient was notified.

In June, Patient 1 underwent an evaluation of abnormal [liver function tests](#) that had been ordered by a community primary care provider and were completed outside of VA. Patient 1 was eventually diagnosed with pancreatic cancer.<sup>30</sup>

In addition, from May to June 2019, Patient 1 made five calls requesting a refill of pain medication for chronic back pain that were referred to the patient’s provider. One of the requests was refilled by another provider in mid-July and two other requests were not acknowledged by

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<sup>28</sup> VHA Directive 1088.

<sup>29</sup> VHA Directive 1232(2).

<sup>30</sup> Mayo Clinic, *Pancreatic Cancer*. <https://www.mayoclinic.org/diseases-conditions/pancreatic-cancer/symptoms-causes/syc-20355421>. (The website was accessed on February 6, 2020.) Symptoms in pancreatic cancer may not develop until late in the disease and are typically related to blockage in the ducts of the pancreas.

either the provider or supervising physician, for a required co-signature, until a month and a half after the requests were made. Patient 1 died in mid-October 2019.

The failure of the provider to manage Patient 1's results, as well as the lack of response to the pain medication refill requests, created missed opportunities to diagnose the cancer up to two months earlier. In addition, the OIG determined that had the abnormal laboratory test and imaging results been managed in mid-April, the provider may have had an opportunity to employ interventions to manage pain and anxiety and possibly extend the patient's life. The OIG acknowledges that these interventions would not have ultimately changed the patient's outcome.

### *Delay in Managing Abnormal PSA Results*

The OIG reviewed 10 patient cases provided by the complainant concerning potential delays in managing abnormal PSA results, which may have resulted in delayed diagnoses of prostate cancer. The OIG recognizes that not all elevated PSAs are directly related to cancer and there are other benign medical circumstances for elevated PSAs.

The OIG found that in one of the 10 cases, the system provider failed to manage a patient's (Patient 2) elevated PSA levels, despite Patient 2's repeated provider visits over the course of nearly two years. Patient 2, in their early 60s, was seen by a primary care provider in early February 2017, who noted that the patient's PSA was elevated. The provider referred Patient 2 to the urology service, who saw Patient 2 in early March 2017. Documentation in the EHR indicated that the urologist discussed the elevated PSA level with Patient 2 and planned to have the patient's primary care provider recheck a PSA level in six months.

A newly assigned primary care provider saw Patient 2 in September 2017 and documented that the patient's other laboratory test results were discussed with and given to the patient, but there was no documentation of the patient's elevated PSA from that day. The primary care provider saw Patient 2 twice in 2018, and again in mid-May 2019. During each of these visits, the primary care provider documented that the patient's laboratory test results were reviewed; however, the patient's PSA levels, which remained elevated, were not specifically mentioned. In early August 2019, the provider referred Patient 2 to a urology service in the community for the elevated PSA.

Patient 2 was ultimately diagnosed with prostate cancer by the community provider in early November 2019 based on biopsy results. The failure of the system primary care provider to manage Patient 2's elevated PSA levels may have contributed to a delay in diagnosis and initiation of treatment.

The OIG's review of the other nine patients revealed a provider delay in responding to view alerts for elevated PSA levels of 10–376 days for five patients. The OIG determined that four patients had acceptable follow-up care. The remaining five patients' cases were referred to the system for action.

## Non-Treatment of Abnormal Glucose and Cholesterol Levels

The OIG did not substantiate that hundreds of patients with either abnormal glucose or cholesterol levels were never treated. The OIG reviewed 225 patients with abnormal laboratory test results and found three patients with abnormal glucose levels and no patients with abnormal cholesterol levels. The OIG determined after a review of the patients' EHRs that the three patients with abnormal glucose levels were clinically managed.

## Patient Notification of Abnormal Results

The OIG substantiated that patients with view alerts for abnormal laboratory and imaging test results were not consistently notified as required by VHA. The provider or designee must document any communication and subsequent clinical actions in the patient's EHR "in response to critical, urgent, and clinically significant test results that require therapeutic intervention or action."<sup>31</sup>

All test results requiring action, such as abnormal results, must be communicated by the ordering provider or designee to patients no later than seven calendar days from when the results are available. Test results not requiring action, such as normal results, must be communicated to patients no later than 14 calendar days from when they are available.<sup>32</sup>

The OIG reviewed the same 225 patients' EHRs with abnormal laboratory test results noted above that would have generated view alerts and found that 88 patients were not notified of their laboratory results. While all patients with abnormal laboratory results should be notified, the OIG focused on 22 patient cases (of the 88) where there was increased potential for adverse clinical outcomes but no documented evidence of follow-up. The OIG reviewed the 22 patients' EHRs and determined five patients required follow-up for abnormal laboratory test results including [creatinine](#) and [fecal occult blood](#); the five patient cases were referred to the system for action.

The OIG reviewed 275 patients' EHRs with abnormal imaging view alerts that would have generated view alerts and found that 99 patients were not notified of their imaging results as required by VHA (see [Scope and Methodology](#)).<sup>33</sup> While all patients with abnormal imaging results should be notified, the OIG focused on 21 (of the 99) where there was increased potential for adverse clinical outcomes, but no documented evidence of follow-up. The OIG reviewed the 21 patients' EHRs and determined five patients required follow-up for conditions such as [degenerative joint disease](#) or a lung nodule; the five patient cases were referred to the system for action.

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<sup>31</sup> VHA Directive 1088.

<sup>32</sup> VHA Directive 1088.

<sup>33</sup> VHA Directive 1088.



## Provider-to-Provider Notification of Abnormal and Critical Test Results

The OIG did not substantiate that the system excluded [teleradiologists](#) from the requirement to communicate abnormal and critical test results to ordering providers or their designees, as alleged during an inspection interview. Although not an allegation, the OIG also reviewed provider-to-provider communication of abnormal and critical laboratory test results. The OIG determined that diagnostic providers notified ordering providers of abnormal and critical laboratory and imaging test results as required by VHA.

VHA requires “that all test results be communicated by the diagnostic provider to the ordering provider, or designee, within a time frame that allows for prompt attention and appropriate action to be taken.”<sup>34</sup> For example, abnormal results are required to be communicated via view alert within seven days. The system requires that critical results be verbally communicated by phone within 15 minutes by the diagnostic provider to the ordering provider or designee.<sup>35</sup>

The OIG determined that there were 10 laboratory tests (of the 225 reviewed) labeled critical (see [Scope and Methodology](#)). The critical values were communicated by diagnostic providers to ordering providers or designees as required. Documentation in the EHR included the name of the diagnostic provider and the name of the ordering provider that was notified, the date and time of notification, and a statement that the read-back was correct.<sup>36</sup>

The OIG reviewed 275 EHRs of patients with abnormal imaging results and found two with the diagnostic code “critical abnormality” (see [Scope and Methodology](#)). Both EHRs contained documentation that teleradiologists notified ordering providers of critical test results and received read-back verification.

### 3. Community Care Consults

The OIG substantiated that unscheduled community care consults were administratively closed after 90 days, regardless of the reason for the consult. However, the OIG found that these actions complied with VHA requirements.

A community care consult is “a request for hospital care and/or medical services to be purchased in the community when the care/services cannot be physically furnished by VA facilities; the

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<sup>34</sup> VHA Directive 1088.

<sup>35</sup> Facility Memorandum No. 11-18-33.

<sup>36</sup> Doris M. Haverstick, Critical Value Called, Read-Back Obtained, *American Journal of Clinical Pathology* 121, (2004): 790-791. Read-back occurs when a diagnostic provider reports a critical test result and the receiving staff read-back the results to verify the accuracy of the critical test result.



Veteran cannot safely travel due to medical reasons; care cannot be furnished in a timely manner in VA facilities; or care cannot be furnished due to geographic inaccessibility.”<sup>37</sup>

According to VHA requirements, providers use administrative consults to document transfer requests and place orders, and clinical consults to request an “opinion, advice, or expertise regarding evaluation or management of a specific problem.”<sup>38</sup> VHA requires that consults be acted on by the receiving service no later than two business days from receipt.<sup>39</sup>

It is essential for facilities to manage consults in a timely manner to help prevent extended wait times for patient appointments. VHA requirements specify that consults should be scheduled within 30 days and not be more than 90 days old from consult receipt.<sup>40</sup> VHA specifies criteria for consult closure when the requested care or service has not yet been provided. In the context of this review, the two most relevant methods are defined below:

- *Discontinue*. This method allows the ordering and receiving providers to discontinue a consult when it is no longer wanted or needed.<sup>41</sup>
- *Cancel or Deny*. This method can be selected by the receiving service to return a consult request to the sender. Examples include when the ordering provider did not ask an appropriate consult question or provide sufficient information, the consult pre-work was inadequate, or the requested service was not available. These consults should not be resubmitted if they are more than 90 days old.<sup>42</sup>

If a consult is discontinued or canceled for any reason, a view alert is automatically sent to the ordering provider. Ordering providers must take appropriate action and either edit and resubmit the canceled consult or enter a new consult if the original one was discontinued and the service is still needed.<sup>43</sup>

The OIG reviewed 385 administratively closed community care consults entered from June 1 to November 30, 2019, and found 64 consults that were administratively closed more than 90 days

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<sup>37</sup> VHA Directive 1232(2). *Consult Processes and Procedures*, August 23, 2016.

<sup>38</sup> VHA Directive 1232(2).

<sup>39</sup> VHA Directive 1232(2).

<sup>40</sup> VHA Office of Community Care Field Guidebook.

<https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. (The website was accessed on March 18, 2020.) This is an internal VA website not available to the general public.

<sup>41</sup> VHA Directive 1232(2). “Consults may be discontinued by administrative staff without provider review under the following conditions: duplicate request; care will be provided through a community care consult; a community care appointment has been scheduled; the patient is deceased; the patient refuses care; care has already been provided in the community; the provider documented instructions to discontinue consult; the patient failed to respond to initial minimum scheduling attempts; or the patient no-showed or canceled and failed to respond to minimum scheduling attempts to reschedule.”

<sup>42</sup> VHA Directive 1232(2).

<sup>43</sup> VHA Directive 1232(2).

after they were requested. Forty-four of the 64 consults were discontinued for various reasons, such as the schedulers were unable to contact the patient, the patient refused the care, or it was a duplicate consult. The remaining 20 consults were canceled by the system's Community Care Office in accordance with VHA requirements because additional information was needed, and view alerts were sent to the ordering providers.<sup>44</sup> Although the canceled consults were not resubmitted and were discontinued after 90 days in accordance with VHA requirements, the OIG found that ordering providers did not consistently take appropriate actions to edit and resubmit the canceled consults as required by VHA. Fourteen of the 20 canceled consults resulted in potential delays in care due to either no action or incorrect ordering provider action.

The OIG reviewed the 14 canceled consults and determined that two consults required further review; the two consults were referred to the system for action.<sup>45</sup>

When ordering providers do not follow VHA guidance to address canceled and discontinued community care consults, patients are at risk for missing needed treatment and follow-up, which could result in adverse clinical outcomes.

#### **4. System Leadership Responsiveness**

The OIG substantiated that the interim COS became aware of the unaddressed view alert backlog after being detailed to the position in May 2019. The OIG found that while the interim COS and other leaders took actions to reduce the number of view alerts (see [Sequence of Events](#)), the leaders' response did not include sufficient activities needed to ensure patient care and safety.

As noted previously, at the time of the OIG site visit in early December 2019, the system's executive leaders were all in interim or acting roles and the OIG was unable to interview responsible leaders with historical knowledge of the view alert issue and action plans.

Further, there had been six interim or acting COSs at the system between 2017 and 2019. On September 6, 2019, the VISN reported to the OIG that despite repeated efforts to recruit a permanent COS, and with at least one selection made but later declined by the selectee, the system had been unable to secure and retain a permanent COS. On September 21, 2019, approximately two weeks after the OIG closed a report recommendation (see [Prior OIG Reports](#)), the OIG learned that the System Director was retiring on September 28, and the Deputy Director and ADPCS were reassigned to other positions "pending a review" of system operations. The OIG believes that the series of interim or acting COSs, as well as other

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<sup>44</sup> Fifteen of the 20 consults were canceled because all the required eligibility information was not completed. Two were cancelled because the required diagnostic work was not completed before the consult was ordered. One was canceled because the patient did not want community care services. One was canceled because the preliminary diagnosis did not match the consult. One was canceled because it was greater than 10 days old.

<sup>45</sup> In addition to the two canceled consults, the OIG identified six additional discontinued consults that were unrelated to the original allegations. For the purpose of completeness, the OIG sent them to the system for further review and action.

leadership challenges in the previous few years, may have contributed to the system's failure to focus on the monitoring and management of view alerts.

Upon learning of the unaddressed view alert backlog issue in May 2019, the interim COS and other leaders took actions to resolve the condition, and reported that within five months the number of pending system view alerts had been dramatically reduced by 650,000. However, based on provider and other relevant interviews, the OIG determined that leaders did not give providers clear instructions on how to prioritize view alerts for review and disposition, or how to document the actions related to clearing unaddressed view alert backlog. Several system staff members with knowledge of the issues did not express confidence that the cleared view alerts were reviewed and managed appropriately. Because system leaders did not initially incorporate oversight processes, such as audits, they could not be assured the view alerts were being appropriately managed (as opposed to just "deleting" the view alert).<sup>46</sup>

A retrospective review would have revealed for example, one patient had a positive fecal occult blood test, a screening test for colorectal cancer, in January 2019, which would have generated a view alert. A reminder was sent to the provider in May 2019 that was not acknowledged until September 2019, although the provider did not order a colonoscopy at that time. The OIG referred this patient case back to system leaders, and a diagnostic colonoscopy was ultimately ordered in February 2020. Had leaders instituted a retrospective review of the unaddressed view alert backlog, this patient case, and possibly others like it, could have been identified and more timely actions taken to promote patient care and safety.

### **Actions Taken After the OIG's Visit**

The OIG was told that the system initiated a process in February 2020 to perform weekly audits of unaddressed view alerts. This process would allow for contemporary evaluation and intervention related to clinical view alerts. Due to the recency of the weekly audits, the OIG was unable to determine their effectiveness.

System leaders reviewed and followed up on the 33 patient cases referred to the system by the OIG for action. These patient cases were identified during the course of the OIG's inspection and, as of February 3, 2020, each case had clinical issues requiring follow-up including inactive users, abnormal laboratory or imaging results, elevated PSAs, and canceled or discontinued community care consults.<sup>47</sup> The OIG found that clinical interventions were taken or were

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<sup>46</sup> The OIG was told that if a provider uses CPRS to manage view alerts, each alert must be done individually, and that VistA can be used as a work around to delete view alerts. Providers can delete multiple view alerts without managing the test result or other event that triggered the alert. VistA is not unique to the system but available VHA-wide.

<sup>47</sup> The treatment or issues for patients sent to the system included ten inactive users, five abnormal laboratory test results, five abnormal imaging results, five elevated PSAs, and eight discontinued or canceled community care consults.

pending, and that other follow-up actions were adequate. The OIG will continue to monitor until completion of pending actions.

## Conclusion

The OIG did not substantiate that at least 12 providers had each accumulated more than 5,000 view alerts. However, the OIG confirmed that nine providers had more than 5,000 view alerts at some point between July 23 and December 2, 2019. Because of the rolling nature of view alerts, the OIG could not definitively determine how many of the view alerts were laboratory tests and imaging results over six months old.

During a review of unaddressed view alerts, the OIG found opportunities for the system to follow-up on clinical concerns including diabetes management, thyroid imaging, and urology care. The backlog of unaddressed view alerts was exacerbated by contributing factors such as inactive providers without designated surrogates.

Training and resources to support providers in managing their view alerts were available at the system, however, it did not appear those services were widely communicated to or utilized by providers. In addition, providers generally reported that the surrogate designation process was not effective because the increased volume of view alerts made it difficult for providers with surrogate duties to address both their own and another provider's view alerts. The team-based primary care model is intended to ensure timely, coordinated, and continuous care that does not rely on individual providers, but when this fails, view alerts can go unmanaged and patients may not receive appropriate care.

The system should proactively review the view alert process, to include the amount and types of view alerts providers receive, in order to ensure effective view alert management and minimize unnecessary provider workload. In addition, a less individualized approach to view alert management may help relieve the individual provider burden and improve view alert response rates and ultimately patient care.

The OIG substantiated that of the patients reviewed, some patient care was being compromised because abnormal laboratory and imaging results were either not managed or not managed within the required time frame. Some patients were at risk for delayed cancer diagnoses because of the lack of timely provider follow-up. The OIG did not substantiate that hundreds of patients with either abnormal glucose or cholesterol levels were never treated. View alerts are the primary mechanism by which providers are notified of abnormal results and consult status, and provide the opportunity for the prompt response that is required. When providers do not manage view alerts, patients may not receive needed treatment and follow-up.

The OIG did not substantiate that the system excluded teleradiologists from the requirement to communicate abnormal and critical test results to ordering providers or their designees as was

alleged during an inspection interview. The OIG determined that diagnostic providers notified ordering providers of abnormal and critical laboratory test results as required.

Unscheduled community care consults were administratively closed after 90 days regardless of the reason for the consult; however, these actions complied with VHA requirements. The OIG found that ordering providers did not consistently take appropriate actions to edit and resubmit canceled consults. Some canceled consults resulted in potential delays in care due to either no action or incorrect ordering provider action. When ordering providers do not follow VHA guidance to address canceled and discontinued community care consults, patients are at risk for missing needed treatment and follow-up, which could result in adverse clinical outcomes.

The interim COS became aware of the unaddressed view alert backlog after being detailed to the position in May 2019. While the interim COS and other leaders took actions to reduce the number of view alerts, the system leaders' response did not include sufficient activities needed to ensure patient care and safety.

The system's executive leaders were all in interim or acting roles and the OIG was unable to interview responsible leaders with historical knowledge of the view alert issue and action plans. Further, there had been six interim or acting COSs at the system between 2017 and 2019. The OIG believes that the series of interim or acting COSs, as well as other leaders' challenges in the previous few years, may have contributed to the system's failure to focus on the monitoring and management of view alerts.

Based on provider and other relevant interviews, the OIG determined that system leaders did not give providers clear instructions on how to prioritize view alerts for review and disposition, or how to document the actions related to clearing the unaddressed view alert backlog. Because system leaders did not initially incorporate oversight processes, such as audits, they could not be assured that view alerts were being appropriately managed (as opposed to just "deleting" the view alert).

The OIG was told that the system initiated a process to perform weekly audits of unaddressed view alerts to allow for contemporary evaluation and intervention related to clinical view alerts. Due to the recency of the weekly audits, the OIG was unable to determine their effectiveness. System leaders followed up on 33 patient cases referred to the system for action and the OIG found that clinical interventions were taken or were pending, and that other follow-up actions were adequate. The OIG will continue to monitor until completion of pending actions.

The OIG is concerned that the issue of significant failures related to management of view alerts is not limited to this system as evidenced by a prior 2019 report published by the OIG where a recommendation was made to the VHA Under Secretary for Health identifying the need for a fail-safe (computer) system that allowed communication and tracking of test results to provider(s) who coordinate patient notification and appropriate follow-up testing and clinical management, and with the ability to monitor actions taken by the responsible provider(s).

## Recommendations 1–11<sup>48</sup>

1. The Under Secretary for Health maintains consistent acting or interim leaders and expedites hiring of permanent leaders at the Central Alabama Veterans Health Care System.<sup>49</sup>
2. The VA Southeast Network Director ensures continued collaboration with the Central Alabama Veterans Health Care System to facilitate compliance with guidelines related to view alert management and monitors for ongoing efficiency and sustainability.
3. The Central Alabama Veterans Health Care System Director will continue to evaluate and assess the Central Alabama Veterans Health Care System’s view alert management process, effectiveness of its action plan, and modify as indicated.
4. The Central Alabama Veterans Health Care System Director ensures that initial and ongoing provider training and support for the clinical management of view alerts is provided, and monitors compliance.
5. The Central Alabama Veterans Health Care System Director issues guidance and ensures providers are trained on a clearly defined process for the designation of surrogates and the associated responsibilities, and monitors compliance.
6. The Central Alabama Veterans Health Care System Director evaluates the two cases discussed in this report to determine if an institutional disclosure or formal quality management review is needed and takes action accordingly.
7. The Central Alabama Veterans Health Care System Director conducts a retrospective review focusing on the unmanaged abnormal laboratory test and imaging results to include those that have the most potential for adverse clinical outcomes to ensure patients received follow-up care as required by Veterans Health Administration policy.
8. The Central Alabama Veterans Health Care System Director conducts a retrospective review focusing on unscheduled community care consults that were discontinued after 90 days that have the most potential for adverse clinical outcomes to ensure patients received follow-up care as required by Veterans Health Administration policy.
9. The Central Alabama Veterans Health Care System Director ensures the development and implementation of a policy to address the communication of all test results to ordering providers,

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<sup>48</sup> All recommendations in this report addressed to VA leaders are directed to the individual in that position—whether in an interim, acting, or permanent capacity.

<sup>49</sup> Recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge, who had the authority to perform the Under Secretary’s functions and duties. Effective January 20, 2021, he was appointed to Acting Under Secretary for Health with the continued authority to perform the functions and duties of the Under Secretary.

or designee, and to patients as required by Veterans Health Administration policy, and monitors compliance.

10. The Central Alabama Veterans Health Care System Director ensures that audits of abnormal laboratory and imaging test results, and unscheduled community care consults that were discontinued after 90 days, are completed to verify providers have managed the associated view alerts, and monitors compliance.

11. The Central Alabama Veterans Health Care System Director ensures that pending actions are completed for the 33 patient cases with clinical issues referred to the system by the Office of the Inspector General.

## Appendix A: Under Secretary for Health Memorandum

### Department of Veterans Affairs Memorandum

Date: February 2, 2021

From: Acting Under Secretary for Health, Office of the Under Secretary for Health (10N)

Subj: Healthcare Inspection—View Alert Process Failures and the Impact on Patient Care at the  
Central Alabama Veterans Health Care System in Montgomery

To: Assistant Inspector General for Healthcare (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report VETERANS HEALTH ADMINISTRATION: View Alert Process Failures and Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery.
2. The Veterans Health Administration (VHA) concurs with the one recommendation to the USH and noted in the response the actions taken. VHA considers this action complete and requests OIG consider closure.
3. VISN 7 and Central Alabama VA Healthcare System submits the attached action plan for recommendations 2 through 11.
4. If you have any questions, please contact Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at [VHA10BGOALAction@va.gov](mailto:VHA10BGOALAction@va.gov).

*(Original signed by:)*

Richard A. Stone, M.D.

Attachments



## **Under Secretary for Health Response**

### **Recommendation 1**

The Under Secretary for Health maintains consistent acting or interim leaders and expedites hiring of permanent leaders at the Central Alabama Veterans Health Care System.

Concur.

Target date for completion: Complete

### **Executive in Charge Comments**

The Under Secretary for Health has ensured that consistent acting/interim leaders have been in place as outlined below:

An Interim Medical Center Director was detailed from October 2, 2019, until September 26, 2020. The Interim Medical Center Director was selected as the permanent Medical Center Director with an Entry on Duty Date (EOD) date of September 27, 2020.

The Deputy Director position has been filled, with an EOD date of November 26, 2017.

The Associate Director position was filled, with an EOD date of May 24, 2020.

The Interim Chief of Staff was detailed from May 29, 2020, to June 20, 2020. The Interim Chief of Staff was selected as the permanent Chief of Staff with an EOD date of June 21, 2020.

The Interim Associate Director, Nursing and Patient Care Services has been detailed since March 8, 2020 and continues serving in this capacity pending the EOD of the permanent Associate Director, Nursing and Patient Care Services. The permanent Associate Director, Nursing and Patient Care Services has been selected and she is currently being reviewed by the VA Central Office Nursing Board to determine an EOD date.

VHA considers this action complete and requests OIG to consider closure.

### **OIG Comment**

The OIG considers this recommendation open due to a critical leadership position remaining in Interim status.

## Appendix B: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: January 29, 2021

From: Interim Director, VA Southeast Network (10N07)

Subj: Healthcare Inspection—View Alert Process Failures and the Impact on Patient Care at the  
Central Alabama Veterans Health Care System in Montgomery

To: Under Secretary for Health, Office of the Under Secretary for Health (10)  
Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. I have had the opportunity to review the Draft Report – Healthcare Inspection – View Alert Process Failures and the Impact on Patient Care at the Central Alabama VA Healthcare System in Montgomery.
2. VISN 7 and Central Alabama VA Healthcare System submits the attached status update providing justification and documentation to recommendations 2 through 11. I concur with recommendations 2 through 11.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

*(Original signed by:)*

Joe D. Battle  
Network Director

## **VISN Director Response**

### **Recommendation 2**

The VA Southeast Network Director ensures continued collaboration with the Central Alabama Veterans Health Care System to facilitate compliance with guidelines related to view alert management and monitors for ongoing efficiency and sustainability.

Concur.

Target date for completion: June 30, 2021.

### **VISN Director Comments**

The VA Southeast Network Director delegated the Chief Medical Officer's Team to develop and facilitate a Central Alabama Healthcare System View Alert Action Plan with the Central Alabama Chief of Staff and Quality Management Department. This plan assessed the current state, corrected deficiencies and developed a monitoring system for view alert management sustainability. The Chief Medical Officer will obtain evidence from Central Alabama VA Healthcare System monthly as evidence that facility audits of view alerts are sustained at 90% for six consecutive months.

## Appendix C: System Director Memorandum

### Department of Veterans Affairs Memorandum

Date: January 28, 2021

From: Director, Central Alabama Veterans Health Care System, Montgomery, Alabama (619/00)

Subj: Healthcare Inspection—View Alert Process Failures and the Impact on Patient Care at the  
Central Alabama Veterans Health Care System in Montgomery

To: Director, VA Southeast Network (10N07)

1. The System Director has reviewed the draft Healthcare Inspection-View Alert Process Failures and the Impact on Patient Care report for Central Alabama Veterans Health Care System. I concur with the nine (9) recommendations made to include actions developed by CAVHCS to support the facility with sustained compliance.
2. Please express my thanks to the Team for their professionalism and assistance to CAVHCS as we continue to provide quality, patient centered care to all the Veterans we serve.

*(Original signed by:)*

Amir Farooqi, FACHE  
Director

## **System Director Response**

### **Recommendation 3**

The Central Alabama Veterans Health Care System Director will continue to evaluate and assess the Central Alabama Veterans Health Care System's view alert management process, effectiveness of its action plan, and modify as indicated.

Concur.

Target date for completion: January 28, 2021

### **System Director Comments**

The System Director concurs with the recommendation provided. Central Alabama Veterans Health Care System self-identified opportunities in the view alert management process and immediately created an action plan in May 2019 in collaboration with the VISN Clinical Health Informatics Officer. The action plan was developed to assess the effectiveness of the current process and make modifications as a result of failures within those processes. In January 2020, the Healthcare System chartered a View Alerts Sub-Committee, which meets at minimum monthly. This Sub-committee reports directly into the Quality, Safety, Value Council in which the System Director is co-Chair. The Health System continues to monitor the view alert management process effectiveness while also creating modifications as necessary within this forum.

### **OIG Comment**

The OIG considers this recommendation open to allow time for the Central Alabama Veterans Health Care System to submit documentation of actions taken.

### **Recommendation 4**

The Central Alabama Veterans Health Care System Director ensures that initial and ongoing provider training and support for the clinical management of view alerts is provided, and monitors compliance.

Concur.

Target date for completion: February 28, 2021

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The System Director will ensure that initial and ongoing provider training and support for the clinical management of view alerts is provided, and monitoring of

compliance through the development of a Standard Operating Procedure (SOP) for Clinical Management of View Alerts. After SOP development, training for clinical management of view alerts will be provided initially and then annually for providers. An attestation form will be provided by Education Service to the Chief of Staff Office once initial training has successfully been completed by 100% of all applicable provider staff.

## **Recommendation 5**

The Central Alabama Veterans Health Care System Director issues guidance and ensures providers are trained on a clearly defined process for the designation of surrogates and the associated responsibilities, and monitors compliance.

Concur.

Target date for completion: April 30, 2021

## **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The System Director will issue guidance and ensure providers are trained on a clearly defined process for the designation of surrogates and the associated responsibilities, monitoring compliance through the development of a Standard Operating Procedure (SOP) for Surrogacy. Training will be conducted in direct accordance with the SOP, including in new employee orientation. Ninety percent of all providers will receive this training by April 30, 2021. The Clinical Application Coordinators will distribute a monthly report on training and surrogacy compliance by service to the Quality Management Service. This report will be provided to the Quality, Safety, Value Council as a monthly report for six (6) consecutive months for 90% compliance until compliance of surrogacy is sustained. CAVHCS will incorporate this process into periodic monitoring to ensure sustainment and corrective actions as appropriate.

## **Recommendation 6**

The Central Alabama Veterans Health Care System Director evaluates the two cases discussed in this report to determine if an institutional disclosure or formal quality management review is needed and takes action accordingly.

Concur.

Target date for completion: December 15, 2020

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The Health Care System will request the two (2) patients discussed in this report from the Office of the Inspector General. The System Director will ensure the risk manager reviews the two (2) cases identified by the Office of the Inspector General in consultation with the Chief of Staff to evaluate and determine if an institutional disclosure or formal quality management review is needed and take action accordingly as identified in VHA Directive 1004.08, "Disclosure of Adverse Events to Patients."

### **OIG Comment**

The OIG considers this recommendation open to allow time for the Central Alabama Veterans Health Care System to submit documentation of actions taken.

## **Recommendation 7**

The Central Alabama Veterans Health Care System Director conducts a retrospective review focusing on the unmanaged abnormal laboratory test and imaging results to include those that have the most potential for adverse clinical outcomes to ensure patients received follow-up care as required by Veterans Health Administration policy.

Concur.

Target date for completion: February 28, 2021

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The Health System will request the identified patients from the Office of the Inspector General with unmanaged lab results and imaging results to include those identified as having the most potential for adverse clinical outcomes. The System Director will ensure a retrospective review will be completed by the Chief of Staff Service for the patients

identified by the Office of the Inspector General to ensure the patients received the appropriate follow-up care as required by VHA.

### **OIG Comment**

This recommendation tasks Central Alabama Veterans Health Care System to conduct a retrospective review focusing on patients with potential for adverse clinical outcomes, and to ensure patients received follow-up care as required by Veterans Health Administration policy. The review period and thus the patients included in this review will be determined by Central Alabama Veterans Health Care System.

### **Recommendation 8**

The Central Alabama Veterans Health Care System Director conducts a retrospective review focusing on unscheduled community care consults that were discontinued after 90 days that have the most potential for adverse clinical outcomes to ensure patients received follow-up care as required by Veterans Health Administration policy.

Concur.

Target date for completion: February 28, 2021

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The Health System will request the identified patients from the Office of the Inspector General that have the most potential for adverse clinical outcomes. The System Director will ensure the Chief of Staff Service will complete a retrospective review of the patients to ensure the patients received the appropriate follow-up care as required by VHA.

### **OIG Comment**

This recommendation tasks Central Alabama Veterans Health Care System to conduct a retrospective review focusing on patients with unscheduled community care consults that were discontinued after 90 days that have the most potential for adverse clinical outcomes, and to ensure patients received follow-up care as required by Veterans Health Administration policy. The review period and thus the patients included in this review will be determined by the Central Alabama Veterans Health Care System.

### **Recommendation 9**

The Central Alabama Veterans Health Care System Director ensures the development and implementation of a policy to address the communication of all test results to ordering providers,



or designee, and to patients as required by Veterans Health Administration policy, and monitors compliance.

Concur.

Target date for completion: February 15, 2021

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The System Director will ensure the Chief of Staff Service revises the current Facility Policy, 11-18-33, "Notification of Critical Test Results Follow up Action" to include addressing all aspects as required in VHA Directive 1088, "Communication of Test Results to Providers and Patients" The approved implemented policy will address the communication of all test results to ordering providers or designee and patients.

### **Recommendation 10**

The Central Alabama Veterans Health Care System Director ensures that audits of abnormal laboratory and imaging test results and unscheduled community care consults that were discontinued after 90 days, are completed to verify providers have managed the associated view alerts, and monitors compliance.

Concur.

Target date for completion: December 15, 2020

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The System Director will ensure Quality Management Staff conduct monthly randomized sample audits to determine whether abnormal laboratory and imaging test results and unscheduled community care consults that were discontinued after 90 days are completed to verify providers have managed the associated view alerts. The audit reports will be provided to the Medical Executive Council (MEC) for six consecutive months until 90% compliance is achieved. CAVHCS will incorporate this process into periodic monitoring to ensure sustainment of improvement actions as appropriate.

### **OIG Comment**

The OIG considers this recommendation open to allow time for the Central Alabama Veterans Health Care System to submit documentation of actions taken and to ensure that corrective actions have been sustained.

## **Recommendation 11**

The Central Alabama Veterans Health Care System Director ensures that pending actions are completed for the 33 patient cases with clinical issues referred to the system by the Office of the Inspector General.

Concur.

Target date for completion: December 15, 2020

### **System Director Comments**

The System Director attests that additional reasons for noncompliance were considered when developing the action plan. The patient cases with clinical issues have been referred to the system by the Office of the Inspector General. The System Director will ensure the Chief of Staff Service completes review of the patient cases with clinical issues and ensures the appropriate follow-up care has been completed.

### **OIG Comment**

The OIG considers this recommendation open to allow time for the Central Alabama Veterans Health Care System to submit documentation of actions taken.

## Glossary

*To go back, press “alt” and “left arrow” keys.*

**creatinine.** “A chemical waste product that is produced by muscle metabolism.” The level of creatinine in the blood reveals important information about kidney function.<sup>50</sup>

**degenerative joint disease.** “Also referred to as osteoarthritis, is a common “wear and tear” disease that occurs when the cartilage that serves as a cushion in a joint deteriorates.”<sup>51</sup>

**diabetes.** “A group of diseases that affect how the body uses blood sugar” that can lead to “too much sugar in the blood.”<sup>52</sup>

**fecal occult blood.** Small amounts of blood passed in the stool that “may indicate colon cancer or polyps in the colon or rectum” and, typically, “can be detected only through the chemicals used in a fecal occult blood test.”<sup>53</sup>

**glucose.** “The amount of “sugar” in the blood which changes throughout the day and night.” “A normal glucose level two hours after eating is less than 140 mg/dL.”<sup>54</sup>

**liver function tests.** “Blood tests used to help diagnose and monitor liver disease or damage.”<sup>55</sup>

**pancreas.** “A large gland near the stomach that produces insulin and a fluid with enzymes that aid digestion.”<sup>56</sup>

**pancreatic cancer.** A type of cancer that “begins in the tissues of your pancreas – an organ in your abdomen that lies behind the lower part of your stomach.”<sup>57</sup>

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<sup>50</sup> Mayo Clinic, *Creatinine Test*. <https://www.mayoclinic.org/tests-procedures/creatinine-test/about/pac-20384646>. (The website was accessed on April 17, 2020.)

<sup>51</sup> American Academy of Physical Medicine and Rehabilitation, *Degenerative Joint Disease*. <https://www.aapmr.org/about-physiatry/conditions-treatments/pain-neuromuscular-medicine-rehabilitation/degenerative-joint-disease>. (The website was accessed on April 2, 2020.)

<sup>52</sup> Mayo Clinic, *Diabetes*. <https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444>. (The website was accessed on April 2, 2020.)

<sup>53</sup> Mayo Clinic, *Fecal Occult Blood Test*. <https://www.mayoclinic.org/tests-procedures/fecal-occult-blood-test/about/pac-20394112>. (The website was accessed April 2, 2020.)

<sup>54</sup> Virginia Mason, *What are Normal Blood Glucose Levels?* <https://www.virginiamason.org/whatarenormalbloodglucoselevels>. (The website was accessed on April 2, 2020.)

<sup>55</sup> Mayo Clinic, *Liver Function Tests*. <https://www.mayoclinic.org/tests-procedures/liver-function-tests/about/pac-20394595>. (The website was accessed on April 2, 2020.)

<sup>56</sup> Merriam-Webster, *Pancreas*. <https://www.merriam-webster.com/dictionary/pancreas>. (The website was accessed on April 2, 2020.)

<sup>57</sup> Mayo Clinic, *Pancreatic Cancer*. <https://www.mayoclinic.org/diseases-conditions/pancreatic-cancer/symptoms-causes/syc-20355421>. (The website was accessed on September 3, 2020.)

**prostate specific antigen.** “A protein produced by both cancerous and noncancerous tissue in the prostate, a small gland that sits below the bladder in men.” Elevated levels can occur in prostate cancer and in enlargement of the prostate.<sup>58</sup>

**teleradiologist.** A “medical doctor who specializes in diagnosing and treating injuries and diseases using medical imaging procedures such as X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET) and ultrasound.” The teleradiologist is “at a location separate from where the imaging studies are being performed.”<sup>59</sup>

**thyroid.** A gland at the base of the neck that produces hormones which affect growth, development, and the rate at which the body uses energy.<sup>60</sup>

**urology.** A medical specialty that deals with diseases of the urinary tract (kidneys, ureters, bladder and urethra.)<sup>61</sup>

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<sup>58</sup> Mayo Clinic, *PSA test*. <https://www.mayoclinic.org/tests-procedures/psa-test/about/pac-20384731>. (The website was accessed on April 2, 2020.)

<sup>59</sup> American College of Radiology, *What is a Radiologist?* <https://www.acr.org/Practice-Management-Quality-Informatics/Practice-Toolkit/Patient-Resources/About-Radiology>. (The website was accessed on April 18, 2020.); University of Arizona, *Teleradiology: A Brief Overview*. <https://telemedicine.arizona.edu/blog/teleradiology-brief-overview>. (The website was accessed on April 18, 2020.); Merriam-Webster, *Ultrasound*. <https://www.merriam-webster.com/dictionary/ultrasound>. (The website was accessed on April 2, 2020.)

<sup>60</sup> Merriam-Webster, *Thyroid*. <https://www.merriam-webster.com/dictionary/thyroid>. (The website was accessed on April 2, 2020.)

<sup>61</sup> Urology Care Foundation, *What is urology?* <https://www.urologyhealth.org/urologic-conditions/what-is-urology>. (The website was accessed on April 2, 2020.)

## OIG Contact and Staff Acknowledgments

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